

FRAUD TYPE

Check the appropriate box for fraud type: Vehicle Theft, Vehicle Arson, Vehicle Property Damage, Personal Injury Protection, Bodily Injury, Staged Accident, or Other (please describe).

COMPLAINANT NAME

A company or person such as an Insurance Company, Self-Insured, Law Enforcement Agency, Third Party Adjuster, Witness, Informant, or Other that requests the State of Hawaii Insurance Fraud Investigations Branch to take action to investigate alleged irregularities or inappropriate behavior of certain identified parties.

CLAIM NUMBER

The claim number refers to the policy/claim number issued by the Insurance Company, Self-Insured or Third Party Adjuster.

DATE OF LOSS/INJURY

The date of loss/injury refers to the date in which the loss or injury occurred.

LOCATION OF LOSS/INJURY

The location of loss/injury refers to the location where the loss or injury took place. Please indicate the name of city and state.

ADDRESS

The address refers to the street address of the complainant. Please list the full address including the city, state, and zip code.

CONTACT PERSON/FILE HANDLER

The contact person or file handler refers to the person whom the Insurance Fraud Investigation Branch should contact for information relative to this case.

INSURANCE COVERAGE TYPE

Check the appropriate box indicating type of coverage related to this loss: Collision, Comprehensive, Property Damage Liability, Personal Injury Protection, Uninsured Motorist, Underinsured Motorist, Bodily Injury Liability, Other (please describe).

ACTUAL LOSS AMOUNT

The actual loss amount refers to the monetary compensation paid on this claim as of the date of this form.

POTENTIAL LOSS AMOUNT

The potential loss amount refers to the potential loss exposure on this claim as of the date of this form.

INCIDENT/CLAIM REPORTED TO OTHER AGENCY

Refers to the agencies other than the State of Hawaii Insurance Fraud Investigation Branch to which you have reported this information. Please check the appropriate boxes and provide the necessary information: Other Law Enforcement Agency (i.e. HPD, DHS, etc...); NICB, Index System; and/or Other (please describe). List all agencies to which you have reported this incident or claim.

SETTLEMENT

Has a settlement been made on this claim to the SUSPECT? If yes, please indicate when the settlement was made and the amount.

NOTICE OF INVESTIGATION

Has the SUSPECT been notified of this case referral? Has the SUSPECT been made aware of your initiation of a fraud investigation?

ATTACHMENTS

Place check in box if attachments are included. Send all available documents related to the fraudulent activity. e.g. Copy of the policy, policy application, policy declaration sheet, affidavit of theft, proof of loss, witness information, policy reports including theft report and/or theft recovery report, examination under oath, transcript of recorded statements as well as a copy of tape, correspondence from suspects, photos or videos including a copy of negatives, index bureau reports, claim log, doctors' reports, printout of costs incurred by carrier related to claim, front and back of any drafts issued to or on behalf of the claimant, etc.

PRINT NAME

Print the full name of the person completing this form.

POSITION OR TITLE

Print the position or title of person completing this form.

SIGNATURE

Provide the signature of the person completing this form.

DATE

Provide the date that this form was completed.

POLICYHOLDER

Provide information regarding the person insured to include the full name; phone number; address with the city, state, and zip code; employer name; position held; employer address; insured date of birth or age; social security number; tax ID number; driver's license with the state of registration; insured vehicle (year, make, model); license plate number and state in which the car was registered; and the vehicle identification number. Provide the insurance company name; policy/claim #; date of loss/injury.

SUSPECT

Provide information regarding the alleged suspect to include the full name; phone number; address with the city, state, and zip code; employer name; position held; employer address; insured date of birth or age; social security number; tax ID number; driver's license with the state of registration; insured vehicle (year, make, model); license plate number and state in which the car was registered; and the vehicle identification number. Provide the insurance company name; policy/claim #; date of loss/injury. Provide all known (aka's) including nicknames and aliases. Provide the name(s) of any and all company(s) which the insured is doing business as (dba's).

OTHER PARTIES INVOLVED IN THE LOSS

Other parties (involved) to the loss refer to all other participants. Please indicate the relationship of the individual to the loss (i.e. claimant, witness, alias, employer, body shop, medical physician, attorney, etc....) Provide information regarding the insured to include the full name; phone number; address with the city, state, and zip code; employer name; position held; employer address; insured date of birth or age; social security number; tax ID number; driver's license with the state of registration; insured vehicle (year, make, model); license plate number and state in which the car was registered; and the vehicle identification number. Provide all known (aka's) including nicknames and aliases. Provide the name(s) of any and all company(s) which the insured is doing business as (dba's).

ADDITIONAL PARTIES INVOLVED IN THE LOSS

This form may be copied as needed to report additional other parties to the loss. Please indicate the relationship of the individual to the loss (i.e. claimant, witness, alias, employer, body shop, medical physician, attorney, etc....) Provide information regarding the insured to include the full name; phone number; address with the city, state, and zip code; employer name; position held; employer address; insured date of birth or age; social security number; tax ID number; driver's license with the state of registration; insured vehicle (year, make, model); license plate number and state in which the car was registered; and the vehicle identification number. Provide all known (aka's) including nicknames and aliases. Provide the name(s) of any and all company(s) which the insured is doing business as (dba's).

SUMMARY

Please state the facts that support your suspicion of fraudulent insurance claim activity. Attach additional summary sheets if needed. In your summary, please address the following questions: What is the false statement or representation? What proof do you have that the statement or representation is false? How is the false statement or representation material to the claim? What affect did or could the false statement or representation have on the claim?

List specific additional items such as third party statements, patient files and records, doctors notes, appointment books, bank statements, cash receipts and disbursement records, personnel files, etc. which are material to this case and which you believe should be obtained to prove this case beyond a reasonable doubt.